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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

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Revision Type (check all that apply):

___ Amendment
_x_ New
_x_ Repeal

Rule(s) Revised

Chapter Number	**Chapter Title**
0780-01-20	Filing and Approval of Accident and Sickness Policies, Except Credit Accident and Sickness Policies, Premium Rates, and Claims Forms
Rule Number	**Rule Title**
0780-01-20-.01	General Filing Requirements
0780-01-20-.02	Actuarial Memorandum
0780-01-20-.03	Previously Approved Forms
0780-01-20-.04	Experience Records
0780-01-20-.05	Evaluating Experience Data
0780-01-20-.06	Reasonableness of Benefits in Relation to Premiums
0780-01-20-.07	Accident and Health Policy Experience Exhibit
0780-01-20-.08	Effective Date
0780-01-20-.09	Claim Forms for Reporting by Health Care Providers

Chapter Number	**Chapter Title**
0780-01-92	Rules Related to Form and Rate Filings for Health Insurance Coverage Not Subject to the Authority of The Patient Protection and Affordable Care Act of 2010
Rule Number	**Rule Title**
0780-01-92-.01	Definitions
0780-01-92-.02	Application of Chapter
0780-01-92-.03	General Filing Requirements
0780-01-92-.04	Actuarial Memorandum
0780-01-92-.05	Previously Approved Forms
0780-01-92-.06	Experience Records
0780-01-92-.07	Evaluating Experience Data
0780-01-92-.08	Reasonableness of Benefits in Relation to Premium
0780-01-92-.09	Claim Forms for Reporting by Health Care Providers

Chapter Number	**Chapter Title**
0780-01-93	Rules Related to Form and Rate Filings for Health Insurance Coverage Subject to the Authority of The Patient Protection and Affordable Care Act of 2010
Rule Number	**Rule Title**
0780-01-93-.01	Definitions
0780-01-93-.02	Application of Chapter

0780-01-93-.03	General Filing Requirements
0780-01-93-.04	Actuarial Memorandum
0780-01-93-.05	Previously Approved Forms
0780-01-93-.06	Electronic Filing
0780-01-93-.07	Experience Records
0780-01-93-.08	Reasonableness of Benefits in Relation to Premium
0780-01-93-.09	Claim Forms for Reporting by Health Care Providers

Repeal
0780-01-20

Chapter 0780-01-20 "Filing and Approval of Accident and Sickness Policies, Except Credit Accident and Sickness Policies, Premium Rates, and Claims Forms" is repealed.

New Chapter
0780-01-92

Rules Related to Form and Rate Filings for Health Insurance Coverage Not Subject to the Authority of The Patient Protection and Affordable Care Act of 2010

Table of Contents

Rule 0780-01-92-.01 Definitions

As used in this Chapter:

(1) "Accident and health insurance" means insurance against bodily injury, disablement or death, by accident or accidental means, or the expense of bodily injury, disablement or death, against disablement or expense resulting from sickness, and every insurance pertaining thereto; providing for the mental and emotional welfare of an individual and members of the individual's family by defraying the cost of legal services; or providing aggregate or excess stop-loss coverage in connection with employee welfare benefit plans, managed care organizations participating in commercial plans or the TennCare program, or both, health maintenance organizations, long-term care facilities and physician-hospital organizations as defined in T.C.A. § 56-32-102;

(2) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer; it does not include excepted benefits as described by section 2791(c) of the Public Health Service Act, compiled in 42 U.S.C. § 300gg-91(c).

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.02 Application of Chapter

This Chapter shall not apply to health insurance coverage provided to any individual or small employer as regulated by Tenn. Comp. R. & Regs. 0780-01-93. This Chapter shall apply to all other types of accident and health insurance. The provisions of this Chapter are severable. If any provision of this Chapter or its application

to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Chapter which can be given effect without the invalid provision or application.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.03 General Filing Requirements

(1) All the provisions of this Chapter, Rule 0780-01-92-.01 through Rule 0780-01-92-.08, apply to individual policy forms except as specifically provided in Rule 0780-01-92-.03(8).

(2) Each form shall be listed in a cover letter or in an attached list and all covering letters and lists shall be in duplicate. Rates and subsequent rate revisions must be filed with all accident and sickness policy forms as specified in T.C.A. §§ 56-26-102 and 56-26-202, and each policy form filing must be accompanied by a schedule of the proposed premium rates, except revised policy forms previously filed, rider and endorsement forms which do not require a change in rates.

(3) The marketing method to be used (e.g., individual sales, franchise, blanket, direct mail, group) shall be identified. Submission of mass-marketed policies, excluding individually marketed and underwritten policies and group policies as defined in T.C.A. § 56-26-201, shall include a description of the marketing program and state any fees involved.

(4) All filings must be submitted by the company concerned. If the filing is submitted through a third party, the filing should be accompanied by a letter of authorization signed by an officer of the insurance company.

(5) If the form being submitted is intended to replace an approved form already on file, a list of the material changes made in the new form must accompany the transmittal letter.

(6) All blank spaces in each policy form, except an application, must be filled in and completed with hypothetical data to indicate the purpose and use of the form. If there are numerical variables contained within the policy form, the range of variables must be stated in the policy form.

(7) When submitting a policy form to which a copy of the application must be attached when issued, a copy of the appropriate application shall be attached to the policy form. If the application has already been approved, the form number and date of approval shall be stated in the transmittal letter.

(8) The requirements of this paragraph shall apply solely to group accident and sickness policies and forms except for major medical health insurance coverage as referenced in T.C.A. § 56-26-102(d) and to coverage regulated under Tenn. Comp. R. & Regs. 0780-01-93.

(a) As to experience-rated group insurance, premium rates and classifications need not be filed; however, form filings must be accompanied by a statement signed by an authorized person on behalf of the company that:

1. The policy filing is experience-rated group insurance, and

2. The premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.

(b) As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must be accompanied by a certification by an authorized person on behalf of the company that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the commissioner upon request.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.04 Actuarial Memorandum

Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio", of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.05 Previously Approved Forms

Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

(1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form;

(2) A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons;

(3) A history of the experience under existing rates, including at least the data indicated in Rule 0780-1- 92-.06. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data; and

(4) The date and magnitude of each previous rate change, if any.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.06 Experience Records

Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.07 Evaluating Experience Data

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

(1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency;

(2) Experienced and projected trends relative to the kind of coverage, e.g. inflation in medical expenses, economic cycles affecting disability income experience;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations; and

(4) The mix of business by risk classification.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.08 Reasonableness of Benefits in Relation to Premiums

(1) New Forms

With respect to a new form, benefits may be considered reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Non-Cancellable: renewal cannot be declined nor can rates be revised by the insurance company.

If satisfactory justification is submitted to the Department of Insurance for a policy form, including riders and endorsements, under which the expected average annual premium per policy is $100 or more but less than $200, the company may be permitted to subtract up to 5 percentage points from the numbers in the table above, or if less than $100, subtract up to 10 percentage points.

The average annual premium per policy and the average anticipated loss ratio shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

(2) Rate Revisions.

With respect to filings of rate revisions for a previously approved form, benefits may be considered reasonable in relation to premiums provided the following standards are met:

(a) With respect to policies issued on and after the effective date of the revision, the standards are the same as in Paragraph (1) of this Rule, except that the average annual premiums shall be determined based on an actual rather than an anticipated distribution of business.

(b) With respect to policies issued prior to the effective date of the revision, both subparagraph (a) above and this subparagraph (b) shall be at least as great as the standards in Paragraph (1) of this Rule:

1. The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

2. The ratio of (i) to (ii) where:

(i) is the sum of the accumulated benefits, from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and

(ii) is the sum of the accumulated premiums, from the original effective date of the form to the effective date of the revision, and the present value of the future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

3. Other methods, in addition to those in this Paragraph (2) may be used to calculate rate revisions. However, the minimum anticipated loss ratio thus calculated must be at least as great as the standards in Paragraph (1), with consideration given active life reserves, and such methods must be approved by the Insurance Commissioner.

(3) Anticipated loss ratios different from those indicated in Paragraphs (1) and (2) above will require justification based on the special circumstances that may be applicable.

(a) Examples of coverages that may receive special consideration are as follows:

1. accident only;

2. short term non-renewable, e.g., airline trip; student accident;

3. specified peril, e.g., cancer, common carrier; and

4. other special risks.

(b) Examples of other factors that may receive special consideration are as follows:

1. marketing methods, giving due consideration to acquisition and administration costs and to premium mode;

2. extraordinary expenses;

3. high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage; and

4. product features such as long elimination periods, high deductibles and high maximum limits.

(4) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-

112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-92-.09 Claim Forms for Reporting by Health Care Providers

(1) No later than July 1, 1994, all insurance companies offering for sale health care policies in this state shall require all policyholders and third party claimants to utilize the following standardized forms when making a claim against any health care insurance policy in effect in this state:

(a) Centers for Medicare and Medicaid (CMS) Form 1500 for health care practitioner claims other than dental. Health care practitioners who bill patients directly shall provide a properly completed CMS Form 1500 in addition to any other form used to bill the patient when requested by the patient.

(b) Form UB04 for hospital and other institutional care claims. Institutional care practitioners who bill patients directly shall provide a properly completed UB04 in addition to any other form used to bill the patient when requested by the patient.

(c) American Dental Association Claim Form for dental health care claims. Dentists who bill patients directly shall provide a properly completed Claim Form in addition to any other form used to bill the patient when requested by the patient.

(d) The National Council for Prescription Drug Programs (NCPDP) Universal Claim Form for pharmacy claims. Pharmacists who bill patients directly shall provide a properly completed Universal Claim Form in addition to any other form used to bill the patient when requested by the patient.

(e) The ANSI X12N standard format for the health care transaction sets for claims submission (837) and claims payment (835) for all issuers and health care providers who receive claims or sent payment by electronic means.

(2) All forms required by this Rule shall be updated to meet the requirements of federal law or state laws implementing federal or state health care reimbursement programs.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-1008, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

New Chapter
0780-01-93

Rules Related to Form and Rate Filings for Health Insurance Coverage Subject to the Authority of The Patient Protection and Affordable Care Act of 2010

Table of Contents

Rule 0780-01-93-.01 Definitions

As used in this Chapter:

(1) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer; it does not include excepted benefits. For purposes of this Chapter, health insurance coverage shall have the same meaning as that given "major medical health insurance" in T.C.A. § 56-26-102 (d).

(2) "Health insurance issuer" means an entity, including a small employer carrier, subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation.

(3) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(4) "Small employer" has the same meaning given in Title 56, Chapter 7, Section 2203.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2203, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-93-.02 Application of Chapter

(1) The provisions of this Chapter shall apply to health insurance coverage issued to any individual or small employer. The provisions of this Chapter are severable. If any provision of this Chapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Chapter which can be given effect without the invalid provision or application.

(2) This Chapter does not apply to any policy as described by Section 2791(c) of the Public Health Service Act, compiled in 42 U.S.C. § 300gg-91(c).

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2203, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-93-.03 General Filing Requirements

(1) All initial premium rates and forms for new policies and revised premium rates on any previously approved policies must be filed for approval for all health insurance coverage as specified in T.C.A. §56-26-102(a).

(2) Each form shall be listed in a cover letter or in an attached list or in the general filing information of an electronic filing system.

(3) The marketing method to be used (e.g., individual sales, franchise, blanket, direct mail, group, exchanges) shall be identified.

(4) All filings must be submitted by the company concerned. If the filing is submitted through a third party, the filing should be accompanied by a letter of authorization signed by an officer of the insurance company.

(5) All blank spaces in each policy form, except an application, must be filed in and completed with hypothetical data to indicate the purpose and use of the form. If the form includes a range of numerical variables, these variables must be in the actual form.

(6) When submitting a policy form to which a copy of the application must be attached when issued, a copy of the appropriate application shall be attached to the policy form. If the application has already been approved, the form number and date of approval shall be stated in the transmittal letter.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-93-.04 Actuarial Memorandum

Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio hereinafter called "anticipated medical loss ratio", of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-93-.05 Previously Approved Forms

The filing of revised premium rates on any previously approved policy, endorsement, rider, certificate or application shall also include the following:

(1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated medical loss ratio for the form;

(2) A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons it applies only to new or only to in-force business;

(3) A history of the experience under existing rates, including at least the data indicated in Rule 0780-1-93-.07. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data should include: substitution of actual claim run-offs for claim reserves and liabilities; determination of medical loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data;

(4) The date and magnitude of each previous rate change, if any;

(5) Data and documentation in connection with the following must be provided to the extent applicable to the filing under review, with an explanation as to how each item has or has not impacted the premium rate. If the item is not applicable to the filing under review, provide an explanation as to why the item has not impacted the premium rate:

(a) Medical trend changes by major service categories;

(b) Utilization changes by major service categories;

(c) Cost-sharing changes by major service categories;

(d) Benefit changes;

(e) Changes in enrollee risk profile;

(f) Any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

(g) Changes in reserve needs;

(h) Changes in administrative costs related to programs that improve health care quality;

(i) Changes in other administrative costs;

(j) Changes in applicable taxes, licensing, or regulatory fees;

(k) Medical loss ratio;

(l) Health insurance issuer's capital and surplus; and

(m) Other information the Commissioner determines is necessary to review the rates for approval, the requirements will be posted in SERFF;

(6) Filing of Preliminary Justification – In the case of a rate increase of ten percent (10%) or more, or above the State-specific threshold as defined by the Secretary of the U.S. Department of Health and Human Services ("HHS"), pursuant to the HHS final regulation at 45 C.F.R. part 154, Subpart B, Section 200, a health insurance issuer must file with the Tennessee Department of Commerce and Insurance and HHS a Preliminary Justification. The Preliminary Justification must be prepared in accordance with the standards set forth in HHS final regulations at 45 C.F.R. part 154, Subpart B, Section 215, and must contain the following:

(a) Rate Increase Summary (Part I), which must be consistent with the requirements set forth in 45 C.F.R. § 154.215(e); and

(b) A written description justifying the rate increase (Part II), which must be consistent with the requirements set forth in 45 C.F.R. § 154.215(f); and

(7) The review process will include an examination of the following:

(a) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and

(b) The health insurance issuer's data related to past projections and actual experience.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, Public Law 111-148 as amended by Public Law 111-152 (2010), and 45 C.F.R. part 154, Subpart B, Section 200.

Rule 0780-01-93-.06 Electronic Filing

Beginning January 1, 2012, all filings submitted pursuant to this Chapter shall be filed electronically. All electronic filings shall be made via the System for Electronic Rate and Form Filing (SERFF).

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, and 56-32-107.

Rule 0780-01-93-.07 Experience Records

Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, and Public Law 111-148 as amended by Public Law 111-152 (2010).

Rule 0780-01-93-.08 Reasonableness of Benefits in Relation to Premium

(1) New Forms and Rate Revisions

(a) New forms and filings of new premium rates on a previously approved policy, endorsement rider, or certificate benefits will be presumed to be reasonable in relation to premiums provided the anticipated medical loss ratio is at least 80% in the individual and small group markets for all health insurance; however, failure to meet the anticipated medical loss ratio alone will not constitute an unreasonable rate.

(b) The medical loss ratio shall be calculated pursuant to the standards set forth by the U.S. Department of Health and Human Services interim final regulation at 45 C.F.R. part 158 or the corresponding section of any future HHS regulation. For the purposes of this Rule, "small group market" shall mean products sold to employers who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, Public Law 111-148 as amended by Public Law 111-152 (2010), and 45 C.F.R. part 158.

Rule 0780-01-93-.09 Claim Forms for Reporting by Health Care Providers

(1) No later than July 1, 1994, all insurance companies offering for sale health care policies in this state shall require all policyholders and third party claimants to utilize the following standardized forms when making a claim against any health care insurance policy in effect in this state:

(a) Centers for Medicare and Medicaid (CMS) Form 1500 for health care practitioner claims other than dental. Health care practitioners who bill patients directly shall provide a properly completed CMS Form 1500 in addition to any other form used to bill the patient when requested by the patient.

(b) Form UB04 for hospital and other institutional care claims. Institutional care practitioners who bill patients directly shall provide a properly completed UB04 in addition to any other form used to bill the patient when requested by the patient.

(c) American Dental Association Claim Form for dental health care claims. Dentists who bill patients directly shall provide a properly completed Claim Form in addition to any other form used to bill the patient when requested by the patient.

(d) The National Council for Prescription Drug Programs (NCPDP) Universal Claim Form for pharmacy claims. Pharmacists who bill patients directly shall provide a properly completed Universal Claim Form in addition to any other form used to bill the patient when requested by the patient.

(e) The ANSI X12N standard format for the health care transaction sets for claims submission (837) and claims payment (835) for all issuers and health care providers who receive claims or sent payment by electronic means.

(2) All forms required by this Rule shall be updated to meet the requirements of federal law or state laws implementing federal or state health care reimbursement programs.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-1008, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Insurance Division of the Department of Commerce and Insurance on 11/15/11, and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 08/29/2011

Rulemaking Hearing(s) Conducted on: (add more dates). 10/26/2011

Date: 11/15/11

Signature: Julie Mix McPeak

Name of Officer: Julie Mix McPeak

Title of Officer: Commissioner of Commerce and Insurance

Subscribed and sworn to before me on: 11/15/11

Notary Public Signature: Denise M Lewis

My commission expires on: 3/5/12

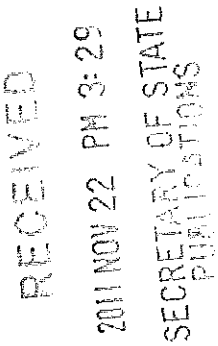
All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

R E Cooper

Robert E. Cooper, Jr.
Attorney General and Reporter

11-18-11
Date

Department of State Use Only



Filed with the Department of State on: 11/22/11

Effective on: 2/20/12

Tre Hargett

Tre Hargett
Secretary of State

Public Hearing Comments

The following are responses to the written comments received by the Division prior to the public hearing held on October, 26 2011 pursuant to T.C.A. § 4-5-222. There were no verbal comments made at the hearing.

Comment 1

Rule 0780-01-93-.03(1) provides that the Chapter is applicable to individual policies with the exception of Rule 0780-01-92-.03(8). However, Rule 0780-01-92-.08 references anticipated loss ratios for non-large group policies suggesting that the rule is applicable to small group policies. We suggest the removal of "non-large group" from the table presented in Rule 0780-01-92-.08 to eliminate confusion.

Response

The Department concurs and has accordingly eliminated "non-large group" from the version of that table that is here represented.

Comment 2

The definitions of "individual health insurance coverage" and "small employer" should be modified to include coverage sold through associations are subject to TDCI rate review in accordance with 45 CFR part 154 and subsequent federal guidelines.

Response

The Division agrees that association plans are subject to state based review of rates under the federal law. No change is necessary to reflect this, however, because as drafted the statute and regulations are crafted to include that type of coverage.

Comment 3

The data and documentation required by Rule 0780-01-93-.05 is indistinguishable from the data and documentation required by 45 CFR part 154. The federal rule requires health plans to provide this documentation when non-grandfathered individual and small group rate increases *exceed* ten percent (10%). Accordingly, we believe that the Tennessee rule should not require plans to submit the additional documentation noted in Rule 0780-01-93-.05 for individual and small group rate increases that are less than ten percent (10%).

Response

The Division disagrees that only increases exceeding ten percent (10%) should be subject to the requirement of Rule 0780-01-93-.05. The Division feels that preserving the right in the rule to ask for this documentation is necessary for the Division to be able to carry out an adequate, thoughtful review of a proposed rate increase of any size, particularly because requests for rate increases are filed in the aggregate. The Division will retain the language as proposed in the notice of rulemaking hearing.

Comment 4

A request was made that the Division clarify that the new Chapters 0780-01-92 and 93 were not meant to apply to credit accident and sickness insurance, and that rate filings for those types of products would continue to be governed by Chapter 0780-01-04.

Response

The Division made this clarification by reading into the hearing record that rate filings for credit accident and sickness policies would continue to be governed by Chapter 0780-01-04 and further would not be subject to Chapters 0780-01-92 or 0780-01-93.

Regulatory Flexibility Addendum
Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The Department of Commerce and Insurance has considered whether the proposed amendments in this notice of rulemaking hearing are such that they will have an economic impact on small businesses (businesses with fifty (50) or fewer employees). The proposed amendments are not anticipated to have a significant economic impact affecting small businesses.

Responses to the analysis criteria set forth in Tenn. Code Ann. § 4-5-403 are as follows:

1. The type or types of small businesses that might be impacted by these proposed regulations may include insurance companies qualifying as small businesses, of which there are very few if any, writing health insurance policies in the individual and small group markets.

2. Those carriers writing in the small group market may experience additional administrative costs as this is a new requirement for that type of policy; however carriers writing individual plans have been subject to rate review for several decades.

3. The only adverse impact that will be borne by small businesses after the enactment of these rules is the time and money involved in compiling relevant documentation and transmitting it to the Insurance Division. The Division has attempted to make the process as efficient as possible by requiring that the filing of documents be done electronically.

4. Alternative means to accomplishing the legislative intent, which is a thorough and complete review of health insurance premium rate filings, does not exist. The Insurance Division must, through federal mandate and as required by state statutes, ensure that every insurance company policy issued that is subject to review under these Chapters is complying with this law.

5. The corresponding federal law is the Patient Protection and Affordable Care Act of 2010 and related regulations.

6. Small businesses could not be exempted. The Department is required by federal law to ensure that all insurance companies writing small group and individual policies of health insurance comply with these regulations.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments."

These amendments have no impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The Insurance Division has prior approval authority over health insurance premium rates as established by 2011 Public Acts Chapter 344. These Chapters establish the process for review of filings for health insurance premium rates on both new products and as amendments to existing products. The Chapters establish the standard for what will be considered a reasonable rate increase, as well as the requirements for supporting documentation for the filings.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

These regulations are authorized by 2011 Public Acts Chapter 344. The passage of the federal Patient Protection and Affordable Care Act of 2010 ("PPACA") and related regulations tasked the federal Center for Consumer Information and Insurance Oversight ("CCIIO") with evaluating each state insurance department's process of reviewing health insurance premium rates. Under PPACA, the consequence of CCIIO finding a state's rate review process inadequate is a federal preemption of the authority to review health insurance premium rates in that state. These regulations are required to make permanent the changes adopted by emergency rulemaking on August 29, 2011, for the purpose of maintaining an adequate rate review process.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Insurance companies licensed to write health insurance in Tennessee are the entities most directly affected by the adoption of these Chapters. The Division had the support of the insurance industry both for the legislation that authorized these rules and the rules themselves, because failure of the Division to have developed a sufficient rate review process would have resulted in federal preemption of the state's authority to review rates.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Division is not aware of any existing opinions or rulings directly relating to the substance of these rules.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The Division already has authority to review rates for health insurance policies issued in the individual market, the additional authority to review small group rates should have only a minimal (truly less than 2%) fiscal impact on the Department's annual budget, if any.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

LaCosta Wix

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

LaCosta Wix

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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